Ancient City Children's Therapy, LLC
910 S. Winterhawk Dr. # 107
St. Augustine, Fl. 32086
(904) 826-7886

Referral for Therapy Services

Date: _____

Client Name: _____ M or F DOB: _____

Address: _____
_____
_____

Phone: _____
Cell:_____

Legal Guardian (relationship if not parent):_____

Person and/or office making referral: _____

Phone: _____

Fax (to send reports to physician): _____

Referring physician: _____

Physician Signature (if prescription not included): _____

PLEASE CHECK ALL APPLICABLE:

1	**Speech Therapy**	**□ Evaluate and Treat As Needed**
2	**Occupational Therapy**	**□ Evaluation Only**
3	**Physical Therapy**	**□ Other: _____**

Referring Diagnosis:
_____

Medical History/Other diagnoses: _____
_____

Additional Comments/Precautions: _____

Primary Insurance: _____

Secondary: _____
INCLUDE COPY OF CARD IF POSSIBLE

Medicaid/Insurance Policy#

_____